Paying the "Tech Tax"

Unlocking Physician-Led ACO Success Through Data and Technology

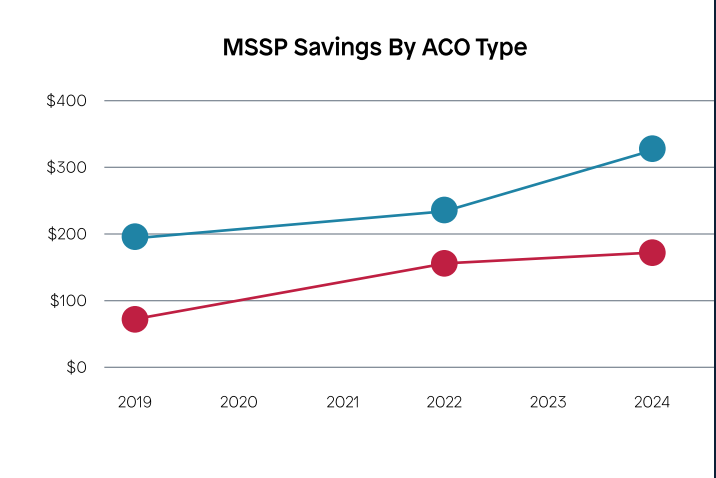
Independent practices have consistently demonstrated strong performance across CMS value-based care models, often outperforming larger or hospital-affiliated organizations. Physician-led groups achieve superior results by investing more heavily in care coordination and disease management, reducing hospitalizations, and leveraging nimble, primary care–led structures that support strong patient engagement.

However, these same strengths create a significant disadvantage in accessing and exchanging CMS data. Although data is essential for clinical care, quality measurement, and population health, physician-led ACOs must make disproportionate investments of time and resources to support data access and exchange compared to larger systems. These challenges limit the role of advanced technology, which to date has been largely confined to telehealth, with AI adoption only beginning.

As more advanced technologies, including AI, become available, data and technology barriers are likely to intensify, creating an "independent practice tech tax" that constrains physician-led ACOs' ability to scale success. This paper examines these challenges and identifies opportunities to reduce burden, improve data access, and better support physician-led models in value-based care.

In fall 2025, PEPC and West Health convened expert roundtables to examine how data and technology support physician-led groups in accountable care and to consider future needs. Participants urged near-term action to remove barriers to data access and exchange, including updating and streamlining policies to improve access and reduce costs.

Physician-Led Groups are Successful in Accountable Care Arrangements



Independent practices have consistently demonstrated strong performance across multiple CMS value-based care models, often outperforming larger or hospital-affiliated organizations. This has held true across programs including the Medicare Shared Savings Program, ACO Investment Model, Next Generation ACO Model, and advanced primary care models such as Comprehensive Primary Care Plus.

Data-Driven Strategies Essential to Success – and Costly

Physician-led value-based care providers have made significant investments in data access and exchange because they recognize that high-quality, timely information is the bedrock of success under risk-based payment models. Actionable, timely data supports coordinate, high-quality clinical care. It also supports other population health activities that are essential to success in an accountable care model such as care coordination, disease management, quality measurement, referrals to high-quality providers, and supporting care transitions. These capabilities depend on integrating multiple data streams, including CMS-provided participant data for attribution and benchmarking, public use files for performance analysis, CCW data accessed through specialized vendors for longitudinal population insights, and real-time hospital event notifications to support timely clinical intervention.

Key Data Sources for Successful Physician-Led Groups

- Data provided to CMS model participants by CMS
- Data made available by CMS as a public use file (PUF)
- Data from Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC), which is generally only accessible to independent physicians or practices who hire a vendor that has already-established access
- Event notifications from local hospitals
- Information from networks and/or health information exchanges

However, independent physician practices face persistent data acquisition challenges due to high integration costs, limited infrastructure, and fragmented systems. Interface development typically costs $5,000 to $15,000 per connection, with monthly maintenance fees ranging from $200 to $500.1 Health Information Exchange (HIE) participation typically ranges from a few hundred to several thousand dollars annually, often between $500 and $1,500 per year for smaller practices in many state and regional HIEs. Total costs can reach several thousand dollars once onboarding, EHR interface fees, and implementation work are included.

As a result, small practices end up paying much more on a per-clinician basis, while large systems can spread those same expenses across a broad workforce. Technology requirements that are routine for large systems can become significant financial burdens for small and independent practices. Actions to Break Down Barriers to Data Sharing to Support Value-Based Care.

Actions to Break Down Barriers to Data Sharing to Support Value-Based Care

Near-term actions should prioritize easing the burden and cost associated with data access and exchange for providers participating in accountable care models.

Opportunity	Why Does This Matter?	Next Steps
Improve mandated event notifications (i.e., admission/ discharge/transfer (ADT) feeds) to streamline communication between physician-led ACOs and hospital	Independent practices rely on timely awareness of hospital or emergency department encounters to initiate rapid outreach, coordinate follow-up care, and prevent avoidable readmissions or repeat ED use. Without ADT alerts, physicians are often unaware of these events until days or weeks later, undermining their ability to meet quality metrics, manage total cost of care, and support patients during vulnerable transitions.	Effective May 2021, CMS required hospitals to send event notifications to providers as a Condition of Participation (CoP) in Medicare and Medicaid. However, gaps in the regulatory framework continue to inhibit widespread implementation of this requirement. CMS should take action to require hospitals to accept patient rosters for purposes of notifications, and to eliminate language simply requiring hospitals to make a "reasonable effort" to identify care relationships.
Shorten real-time data lags and improve data standardization	Accountable care model success demands real-time access to data – data that can be acted on during the performance year; and yet, much of CMS' data is provided after the fact.	Solutions include mandating real-time or near-real-time data feeds, adopting universal data standards such as FHIR for clinical and claims information, and supporting smaller independent practices with the technical infrastructure to ingest and act on this data.
Strong information blocking enforcement	Physicians participating in accountable care arrangements are clinically and financially responsible for their patients' care. Information blocking by other providers and/or EHRs hinders their ability to be successful by ensuring they have a limited or partial view of their patients' health care journey. This undermines their competitiveness and weakens model results.	In July 2025, HHS announced that it would begin enforcing information blocking violations. HHS should use its enforcement authority to send a strong signal that information blocking will not be tolerated to large incumbent providers found to be hoarding patient information for anti-competitive purposes.
Clarify HIPAA definitions of "treatment" and "operations" to support accountable care data exchange	Accountable care model participants often seek information about a panel of attributed patients. This includes data requests for a roster of patients to perform population health activities such as identifying patients who need an Annual Wellness Visit, identifying patients who haven't received an important immunization. Ambiguities in these definitions can create uncertainty about what data can be shared across care teams, with affiliated organizations, or for population health management, potentially slowing care coordination and limiting proactive interventions.	In August 2025, the HHS Office of Civil Rights (OCR) clarified that the HIPAA Privacy Rule permits covered entities to share protected health information with value-based care entities for purposes of treatment without a patient authorization. Additional regulatory clarification would further support providers participating in value-based care arrangements.

Conclusion

Physician-led groups are successful in value-based care models. They rely heavily on data-driven insights to identify opportunities to improve quality and outcomes as well as reduce costs. As such, physician leaders and practices have prioritized investments in data access and exchange over investments such as those in new, innovative technologies. Data access and exchange continues to be administratively burdensome and costly. Near-term actions to improve data access and exchange would reduce burden, allowing practices to invest in other areas.

Appendix — List of Roundtable Participants

Dr. Andrew Albano, Richard Baron Fellow, Primary Care Collaborative
Katie Boyer, Senior Director of Policy & Government Affairs, agilon health
Niamh Brennan, Research Associate, West Health
Sean Cavanaugh, Chief Policy Officer, Aledade
Aneesh Chopra, Chief Strategy Officer, Arcadia
David Ford, Chief Executive Officer, CMA Physician Services
Brendan Fulmer, Vice President, CareBridge
Manisha Goud, Vice President of Solutions, Elation Health
Ann Greiner, President & Chief Executive Officer, Primary Care Collaborative
Mark Japinga, Associate Director of Health Policy, West Health
Maggie Klau, Director, Partnership to Empower Physician-Led Care
Casey Korba, Senior Director of Policy, Aledade
Kristen McGovern, Executive Director, Partnership to Empower Physician-Led Care
Larry McNeely, Director of Policy, Primary Care Collaborative
Dr. Farzad Mostashari, Chief Executive Officer, Aledade
Dr. Sara Pastoor, Head of Primary Care Advancement, Elation Health
Stephanie Quinn, Senior Vice President of External Affairs and Practice Experience, American Academy of Family Physicians
Purva Rawal, Former Chief Strategy Officer, Center for Medicare and Medicare Innovation
Dr. Andrew Schwentker, Physician, Aledade Practice
Dr. Brian Silverstein, Chief Population Health Officer, Innovaccer
Namrata Uberoi, Executive Director, Health Care Cost and Affordability, West Health